The Evolution of Managed Behavioral Healthcare

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Evolution since 1980's

MBHOs

- Rapid growth
- Consolidation
- Differentiation

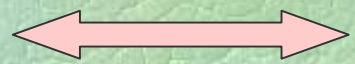
Purchasers

- Controlling costs
- Reduction in hospitalization
- Shorter stays
- Less restrictive levels of treatment

Plateau of costs

Maturity

- Quality assurance
- Managing quality
- Improved product systems

Win  Win

- Purchasers
- Consumers
- Family
- Community

What is managed behavioral healthcare?

MANAGED BEHAVIORAL HEALTHCARE is a strategy for modifying reimbursement structures and delivery systems for mental health, substance abuse and workplace services with an expanded focus on quality of care, administrative and clinical outcomes, and consumer input.

MBHOs

- Multiple services
  - At risk
  - Administrative services only (ASO)
  - Health plan carve outs
  - EAPs
- Consolidation
  - Push to increase core services
  - Address all aspects of continuum of care

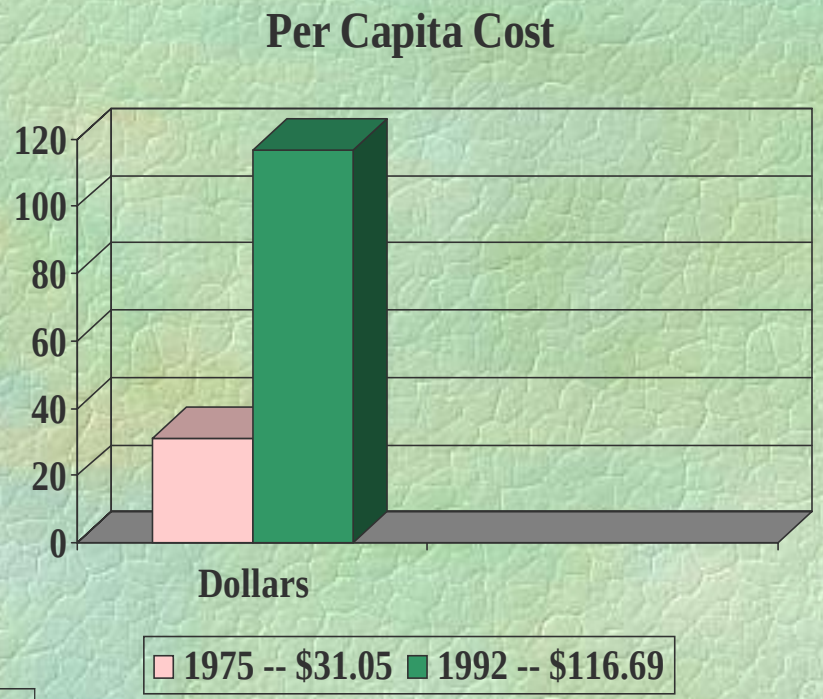
MBHO core functions

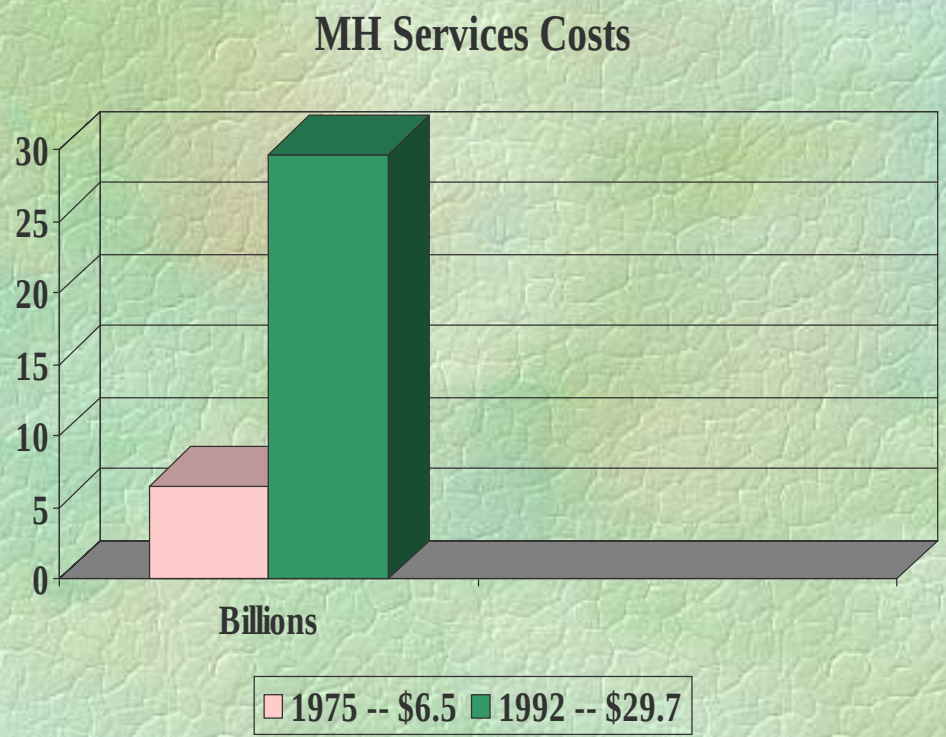
- Care management
- Network management
- Quality improvement
  - Care
  - Service

Why managed behavioral healthcare?

- Regulatory influences: ERISA, TEFRA, and HMO Act
- Problems of cost containment and increased behavioral health expenditures
- Lack of national health insurance and policy
- Expertise in managing care for MHSA and workplace services
- Purchasers seeking economies from available technologies, systems of care and credentialed provider networks

Rising costs

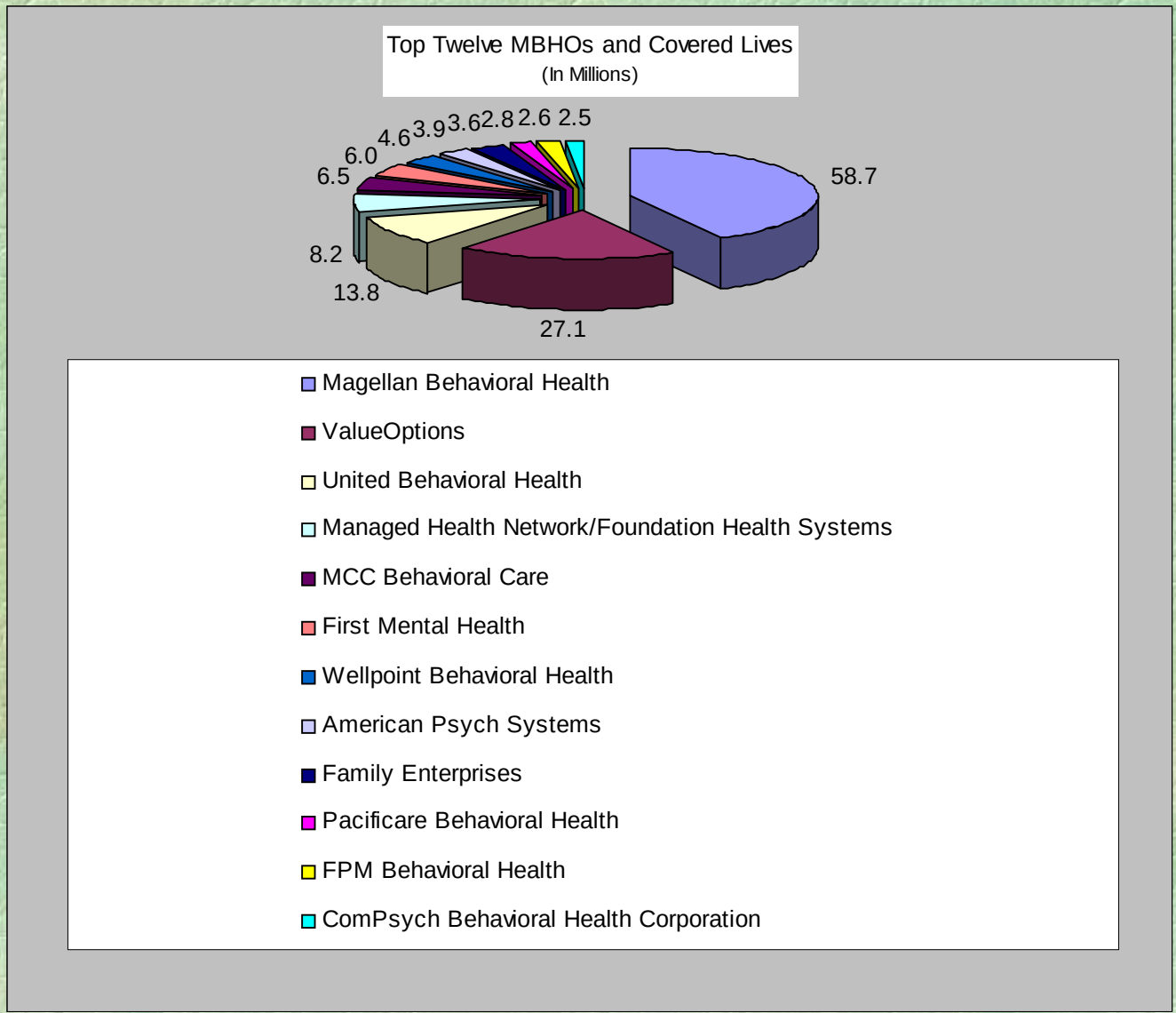




Source: SAMHSA, 1997

Increased presence of managed behavioral healthcare

- Increase observed since the 1980s
- In 1997, reportedly 168.5 million Americans were enrolled in a managed care program
  - Of these, 149 million were managed by a specialty managed behavioral healthcare program and 19.5 million were managed within an HMO
- Number of lives in Medicaid managed care programs increased 500% 1991-1996. Today only 10 states do not have managed behavioral healthcare arrangements.
- By 1997, there were over 30 MBHOs in operation managing more than 136 million covered lives
- Magellan and ValueOptions represent 53% of the total managed behavioral healthcare market



Membership in MBHOs by Organization

Data Source: *Open Minds* (1998). Press Release: 9% increase in managed behavioral health enrollment from 1997:survey identifies largest 12 programs in nation. Gettysburg, PA: Open Minds. June 22, 1998.

What does the MBHO do?

- Behavioral healthcare benefits for a defined population
- Organized delivery system
- Service integration
- Centralized operations
- Mechanisms for performance management

Key functions

- Care management and customer service
- Network management
- Administrative services
- Quality improvement
  - Care and service
  - Primary care integration
  - Prevention
  - Health improvement
  - Workplace services
- Outcomes management
  - Administrative
  - Clinical

Quality improvement

- Identification of opportunities
- Corrective action and ongoing measurement of impact
- Promote satisfaction among consumers, purchasers and providers
- Create an environment to produce improvement in health and well-being, promote recovery, and sustain hope

Activities that Promote Quality in Managed Behavioral Healthcare

Feature/Core Process	Impact on Quality
Clinical Care Management	Burden of the determination of eligibility, explanation of benefits, clinical assessment, triage and referral reduced for the consumer; measurement of consumer and provider satisfaction with the process; after hours assessment and referral; clinical models developed to address special population needs (e.g., Medicare, MediCaid, employee assistance programs and high risk disorders); application of discharge planning guidelines
Network Management	Credentialing and recredentialing assuring providers meet a minimum standard of education, licensing and practice experience; use of provider profiling for performance management; measurement of consumer satisfaction; assuring availability and accessibility; high volume provider strategies
Prevention	Development and implementation of population or disease specific initiatives that address aims of primary, secondary or tertiary prevention; availability of formalized programs with educational tools for consumers and providers; provide opportunity for early detection and risk reduction
Clinical Practice Guidelines	Monitoring of adherence to practice guidelines; assuring consistent application of guidelines by providers in the network; ongoing review and update to reflect most current clinical practices
Medical/Primary Care Integration	Integrate behavioral health care with primary care; develop linkages between behavioral health providers with medical providers; communicate to develop comprehensive treatment plans; reduce risk of misdiagnosis with presenting symptomatology.
Quality Improvement Activities	Development and implementation of long-term quality improvement activities that address clinical and service issues (e.g., high risk disorders, high volume services, and level of care); evaluation of over and under utilization; establish standards for inter-rater reliability for clinical decision-making; provider profiling to assist practitioners in achieving success in managed care arrangements

Challenges and opportunities

- Advancing prevention (effective primary and secondary prevention)
- Outcomes measurement and management
- Meeting standards of different stakeholders
- Shrinking market
- Parity
- Expanding role of the consumer
  - Informed decision-making
  - Addressing needs of the most vulnerable
- Comparability and convergence in performance standards
- Promoting research partnerships
- Joining forces with the provider community